



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

COPY

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November 25, 2009

Kathy Prophet  
Preferred Community Homes - Bedford  
7091 West Emerald Street  
Boise, ID 83704

RE: Preferred Community Homes - Bedford, provider #13G039

Dear Ms. Prophet:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Bedford, which was conducted on November 19, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
3. Identify the date each deficiency has been, or will be, corrected.
4. Sign and date the form(s) in the space provided at the bottom of the first page.

Kathy Prophet  
November 25, 2009  
Page 2 of 2

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **December 7, 2009**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

<http://www.healthandwelfare.idaho.gov/site/3633/default.aspx>

This request must be received by December 7, 2009. If a request for informal dispute resolution is received after December 7, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



MICHAEL A. CASE  
Health Facility Surveyor  
Non-Long Term Care



NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

MC/mlw

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/23/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/19/2009</b>
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NAME OF PROVIDER OR SUPPLIER

**PREFERRED COMMUNITY HOMES - BEDFORD**

STREET ADDRESS, CITY, STATE, ZIP CODE

**398 EDGAR COURT  
MERIDIAN, ID 83642**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS  The following deficiencies were cited during the annual recertification survey.  The survey was conducted by: Michael Case, LSW, QMRP, Team Lead Matt Hauser, QMRP  Common abbreviations/symbols used in this report are:  IDT - Interdisciplinary Team PRN - As Needed QMRP - Qualified Mental Retardation Professional RN - Registered Nurse RSC - Resident Service Coordinator	W 000	"Preparation and implementation of this plan of correction does not constitute admission or agreement by Bedford with the facts, findings or other statements as alleged by the state agency dated November 19, 2009. Submission of this plan of correction is required by law and does not evidence the truth of any or some of the findings as stated by the survey agency. Bedford - Preferred Community Homes, specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action."	
W 111	483.410(c)(1) CLIENT RECORDS  The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.  This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to maintain a record keeping system that contained accurate and complete information for 3 of 3 individuals (Individuals #1 - #3) whose records were reviewed. This resulted in a lack of complete, accurate information being available in the individuals' records. The findings include:  1. Individual #3's 9/09 Physician's Order stated he was a 53 year old male whose diagnoses included profound mental retardation. His PRN medication records, dated 1/09 - 9/30/09, were	W 111	<b>W 111 483.410(c)(1) CLIENT RECORDS</b>  Corrective action to include a change in the system in regard to PRN documentation. All clients have the potential to be affected by this deficient practice. The system change will be as follows: When staff call nursing and a PRN medication is ordered, the nurse will provide a verbal reminder to staff to check back within the hour to determine effectiveness of the PRN. Nursing will instruct staff to document "yes" if the medication was effective, and "no" if the medication was not effective. If "no" is documented, the staff will be instructed to call nursing for further instructions.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

**FACILITY STANDARDS**

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - BEDFORD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>398 EDGAR COURT MERIDIAN, ID 83642</b>		
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W 111	<p>Continued From page 1</p> <p>reviewed and documented he received the following:</p> <ul style="list-style-type: none"> <li>- 1/12/09 at 8:15 a.m.: Milk of Magnesia (a laxative drug) was given for constipation.</li> <li>- 1/23/09 at 9:00 a.m.: Tylenol (a nonopioid analgesic drug) was given for discomfort.</li> <li>- 2/9/09 at 10:00 a.m.: Milk of Magnesia was given for constipation.</li> <li>- 2/13/09 at 7:50 a.m.: Tussin (an antitussive drug) was given for coughing.</li> <li>- 2/13/09 at 7:50 a.m.: APAP (a nonopioid analgesic drug) was given for discomfort.</li> <li>- 2/17/09 at 9:20 a.m.: Tussin was given for coughing.</li> <li>- 2/18/09 at 4:30 p.m.: Robitussin (an antitussive drug) was given for coughing.</li> <li>- 4/2/09 at 8:00 a.m.: Milk of Magnesia was given for constipation.</li> <li>- 4/2/09 at 8:00 a.m.: Prune juice (a laxative treatment) was given for constipation.</li> <li>- 4/4/09 at 12:05 p.m.: Tylenol was given for discomfort.</li> <li>- 4/15/09 at 7:20 a.m.: Milk of Magnesia was given for constipation.</li> <li>- 4/15/09 at 7:20 a.m.: Prune juice was given for constipation.</li> <li>- 4/15/09 at 7:20 a.m.: Tylenol was given for discomfort.</li> <li>- 4/20/09 at 10:20 a.m.: Milk of Magnesia was given for discomfort.</li> <li>- 4/20/09 at 10:20 a.m.: Prune juice was given for discomfort.</li> <li>- 6/1/09 at 2:10 p.m.: Tylenol was given for discomfort.</li> <li>- 6/2/09 at 10:45 a.m.: Tylenol was given for "agitation."</li> <li>- 6/16/09 at 9:40 a.m.: Tylenol was given for "irritability."</li> </ul>	W 111	<p>Each shift, the medication double checker will be responsible for reviewing the current shift's PRN documentation to ensure the documentation is accurate and complete. If documentation is not complete, the double checker will refer the information to the Lead Worker or Shift Charge for further follow-up. The Lead Worker or Shift Charge will conduct an audit before the end of each shift specifically related to PRN documentation. The audit documentation will be included in the double check section of the MAR. If the PRN documentation is not complete, the Lead Worker or Shift Charge will resolve the documentation issue before the next shift. The house LPN will conduct a weekly audit to ensure the PRN documentation is complete and that the Lead Worker or Shift Charge is completing the shift audits. All staff will be in-serviced regarding PRN documentation; the in-service will include the double checker and Lead Worker/Shift Charge's role in ensuring documentation is complete. The in-service will be completed by December 28, 2009. All patient MARs will be revised to include the Lead Worker / Shift Charge audit in the double check section.</p> <p>Person Responsible: Lead Worker or Shift charge, LPN Completion Date: 1-1-10</p>		

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W 111	<p>Continued From page 2</p> <ul style="list-style-type: none"> <li>- 6/16/09 at 9:40 a.m.: Milk of Magnesia was given for "irritability."</li> <li>- 7/13/09 at 7:30 a.m.: Milk of Magnesia was given for constipation.</li> <li>- 8/26/09 at 8:00 p.m.: MiraLax (a laxative drug) was given for constipation.</li> </ul> <p>However, his record did not contain documentation of the effectiveness of the medications and treatments. In addition, the PRN medication and treatment given on 4/20/09 did not include a staff signature.</p> <p>Without consistent documentation, the facility would not be able to assess and report to the physician the effectiveness of the medications and treatments.</p> <p>When asked during an interview on 11/18/09 from 2:55 - 4:35 p.m., the RN stated the effectiveness of the medications and treatments should have been documented.</p> <p>2. Individual #1's 9/09 Physician's Orders stated he was a 57 year old male whose diagnoses included mild mental retardation. His PRN medication records, dated 1/09 - 9/30/09, were reviewed and documented he received the following:</p> <ul style="list-style-type: none"> <li>- 4/27/09 at 1:20 p.m.: Geri-lanta (an antilflatulent drug) was given for a stomachache.</li> <li>- 4/27/09 at 1:20 p.m.: Tylenol was given for a headache.</li> <li>- 5/24/09 at 3:05 p.m.: Tylenol was given for a headache.</li> <li>- 5/27/09 at 10:15 a.m.: Benadryl (an antihistamine drug) was given for red eyes.</li> <li>- 6/15/09 at 2:55 p.m.: Tylenol was given for a</li> </ul>	W 111			

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W 111	<p>Continued From page 3</p> <p>headache.</p> <ul style="list-style-type: none"> <li>- 7/20/09 at 2:15 p.m.: Benadryl was given for cold symptoms.</li> <li>- 7/21/09 at 2:15 p.m.: APAP was given for discomfort.</li> <li>- 8/13/09 at 10:00 a.m.: Milk of Magnesia was given for discomfort.</li> <li>- 8/13/09 at 10:00 a.m.: APAP was given for discomfort.</li> <li>- 8/21/09 at 7:40 a.m.: APAP was given for knee pain.</li> </ul> <p>However, his record did not contain documentation of the effectiveness of the medications.</p> <p>Without consistent documentation, the facility would not be able to assess and report to the physician the effectiveness of the medications and treatments.</p> <p>When asked during an interview on 11/18/09 from 2:55 - 4:35 p.m., the RN stated the effectiveness of the medications and treatments should have been documented.</p> <p>3. Individual #2's 9/09 Physician's Order stated he was a 45 year old male whose diagnoses included severe mental retardation. His PRN medication records, dated 1/09 - 9/30/09, were reviewed and documented he received the following:</p> <ul style="list-style-type: none"> <li>- 4/30/09 at 10:30 a.m.: Tylenol was given for "cold/allergy."</li> <li>- 4/30/09 at 10:30 a.m.: Benadryl was given for "cold/allergy."</li> <li>- 5/6/09 at 8:30 a.m.: Tylenol was given for discomfort.</li> </ul>	W 111			

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W 111	Continued From page 4 - 7/18/09 at 4:20 p.m.: Benadryl was given for scratching. - 8/18/09 at 10:45 a.m.: Milk of Magnesia was given for constipation.  However, his record did not contain documentation of the effectiveness of the medications.  Without consistent documentation, the facility would not be able to assess and report to the physician the effectiveness of the medications and treatments.  When asked during an interview on 11/18/09 from 2:55 - 4:35 p.m., the RN stated the effectiveness of the medications and treatments should have been documented.  The facility failed to ensure Individual #1, #2, and #3's records contained information regarding the effectiveness of PRN treatments and medications.	W 111			
W 312	483.450(e)(2) DRUG USAGE  Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of the individuals' Person Centered Lifestyle Plans that were directed	W 312	<b>W 312 483.450(e)(2) DRUG USAGE</b>  W312- Individual #3's and all other individuals living in the Bedford facility Medication Reduction Plan's has been reviewed and now includes clear and accurate information related to the reduction and eventual elimination of the behaviors for which the medications were employed. Individual #2 living in the Bedford facility now has clear information regarding which signs and symptoms are being tracked for his depressive symptoms.		

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W 312	<p>Continued From page 5</p> <p>specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 2 of 3 individuals (Individuals #2 and #3) whose medication reduction plans were reviewed. This resulted in individuals receiving behavior modifying drugs without plans that identified the drugs usage and how they may change in relation to progress or regression. The findings include:</p> <p>1. Individual #3's Person Centered Lifestyle Plan, dated 7/1/09, documented a 53 year old male diagnosed with profound mental retardation and mood disorder.</p> <p>Individual #3's Physician Orders, dated 10/09, stated he received Zyprexa (an antidepressant drug) 3.75 mg each evening.</p> <p>Individual #3's Medication Reduction Plan, revised 7/7/09, stated the reduction criteria for Zyprexa was less than 10 episodes of SIB (Self Injurious Behavior) for 3 consecutive months. Individual #3's SIB was defined as hitting his back or head with his hand, biting his knuckles or arms, and throwing his body forward or backwards to bang his head.</p> <p>However, Individual #3's QMRP Tracking Form, undated, documented his SIB data as follows:</p> <p>2/09 - 2 episodes. 3/09 - 0 episodes. 4/09 - 0 episodes. 5/09 - 0 episodes. 6/09 - 1 episode and 1 attempt.</p> <p>Additionally, Individual #3's Program Summaries, for July and August of 2009, documented he had</p>	W 312	<p><b>All other individuals living in the Bedford facility who receive behavior modification drugs have had their medication reduction plans reviewed to ensure all behaviors displayed are being tracked and documented properly.</b></p> <p><b>Person Responsible: QMRP, AQMRP</b> <b>Completion Date: 3-7-10</b></p>	

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W 312	<p>Continued From page 6</p> <p>no episodes of SIB during those months.</p> <p>When asked, the QMRP stated during an interview on 11/18/09 at 3:00 p.m., the reduction criteria for Individual #3's Zyprexa should not have been set at less than 10 episodes of SIB for 3 consecutive months,</p> <p>The facility failed to ensure Individual #3's Medication Reduction Plan contained an accurate criteria and current information related to his behavior for which the drugs were prescribed.</p> <p>2. Individual #2's 9/09 Physician's Order stated he was a 45 year old male whose diagnoses included severe mental retardation. His Physician's Order stated he received Zoloft (an antidepressant drug) 50 mg each morning.</p> <p>Individual #2's Physician's Sheet and Progress Notes, dated 5/13/08 and signed by the psychiatric provider, stated Zoloft was prescribed for depressive symptoms which included irritability, decreased appetite, fluctuating sleep patterns including fatigue, isolating in bed, and crying.</p> <p>Individual #2's Medication Reduction Plan, revised 6/24/09, stated Zoloft would be reduced if crying was at less than 25 incidents per month for six consecutive months.</p> <p>The Medication Reduction Plan did not document a correlation to any depressive symptoms other than crying. However, Individual #2's Depressive-Type Symptoms sheet included irritable mood, depressed mood, diminished interest in activities, weight loss or gain, increased or decreased appetite, change in sleep</p>	W 312			

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W 312	<p>Continued From page 7</p> <p>pattern, psychomotor agitation or retardation, fatigue or loss of energy, feelings of guilt or worthlessness, decrease in ability to think, thoughts of death or suicide, crying for no reason, feeling ill-vomiting, and lying on bed-isolating at odd times.</p> <p>Additionally, Individual #2's QMRP Tracking Form included an objective which stated he would have 10 or fewer depressive symptoms per month for 12 consecutive months. The QMRP Tracking Form did not define depressive symptoms, and did not indicate if the criteria was specific to crying as defined on the Medication Reduction Plan, or included other symptoms as listed on the Depressive-Type Symptoms tracking sheet.</p> <p>A review of the completed Depressive-Type Symptoms tracking sheets, dated 5/09 - 9/09, showed the data documented on the QMRP Tracking Form was a composite of all the signs and symptoms listed on the Depressive-Type Symptoms tracking sheet.</p> <p>Without clear information regarding which signs and symptoms were to be tracked in relation to Individual #2's depression for which he received Zoloft, the facility would not be able to present clear and accurate information to the psychiatric provider or IDT regarding the effectiveness of the drug. For example, Individual #2's QMRP Tracking Form documented 29 Depressive Type Symptoms for 5/09. However, his Depressive-Type Symptoms tracking sheets for 5/09 documented he engaged in crying for no reason 3 times.</p> <p>When asked during an interview on 11/18/09 from 2:55 - 4:35 p.m., the QMRP stated the only thing</p>	W 312			

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W 312	Continued From page 8 she believed was tracked for Individual #2's Zolofit was crying. The QMRP stated Individual #2's "crying" data was not separated out, and the medication reduction plan needed to be revised to include all information for which the medication was prescribed.			W 312			
W 436	<p>The facility failed to ensure Individual #2's Zolofit was used only as an integral part of his program plan.</p> <p><b>483.470(g)(2) SPACE AND EQUIPMENT</b></p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure individuals' wheelchairs were kept clean and maintained in good repair for 4 or 4 individuals (Individuals #1 and #4 - #6) observed to utilize wheel chairs. This resulted in individuals' wheelchairs being maintained in ill repair and unsanitary condition. The findings include:</p> <p>1. Adaptive equipment was inspected on 11/17/09 from 7:00 - 8:20 a.m. During that time, the following concerns were noted:</p> <p>For Individual #1: - The left side of his wheelchair, including the break mechanism, frame, and footrest mount were covered with dried food debris.</p>			W 436	<p><b>W 436 483.470(g)(2) SPACE AND EQUIPMENT</b></p> <p>W436-Individual #1's left side of his wheelchair, including the break mechanism, frame, and footrest mount have been scrubbed down and cleaned. Individual #4's wheelchair (both sides) including the break mechanisms, frame, and footrest mounts have been scrubbed and cleaned, the right foot rest and padded leg brace that runs across the front of the chair between the supports, continues to be on order. Individual #5's entire wheel chair has been cleaned and scrubbed. Individual #6's entire wheelchair has been scrubbed and cleaned and the anti-tip bars have been ordered to be replaced.</p> <p>Individual client programs will be implemented for each client at Bedford to ensure that they are participating in learning to clean and care for their own wheelchairs daily.</p> <p>Person Responsible: QMRP, RSC Completion Date: 3-7-10</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/23/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G039</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/19/2009</b>	
NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - BEDFORD</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>398 EDGAR COURT MERIDIAN, ID 83642</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 436	<p>Continued From page 9</p> <p>For Individual #4: - Both sides of his wheelchair, including the break mechanisms, frame, and footrest mounts were covered with a build up of dirt and grime. - The right footrest was missing. - There was a 2 inch tear in the padded leg brace that ran across the front of the chair between the supports.</p> <p>For Individual #5: - Both sides of her wheelchair, including the break mechanisms, frame, and footrest mounts were covered with food debris.</p> <p>For Individual #6 - Both sides of her wheelchair, including the break mechanisms, frame, and footrest mounts were covered with food debris. - The wheels on her right anti-tip bar were broken.</p> <p>When asked during an interview on 11/17/09 at 1:05 p.m., the RSC stated individuals' wheelchairs were to be cleaned during the graveyard shift. The RSC stated Individual #4's right footrest had been broken off and on for approximately 6 months, and that the facility was in process of having him refitted for a new wheelchair.</p> <p>When asked during an interview on 11/18/09 from 2:55 - 4:35 p.m., the Administrator confirmed graveyard staff were to clean individuals' wheelchairs, and the RSC was to monitor. The Administrator stated the facility was in process of getting a new chair approved for Individual #4.</p> <p>The facility was cited at W436 during their follow up survey dated 5/26/09. The corresponding</p>			W 436			

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NAME OF PROVIDER OR SUPPLIER  <b>PREFERRED COMMUNITY HOMES - BEDFORD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>398 EDGAR COURT MERIDIAN, ID 83642</b>		
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W 436	<p>Continued From page 10</p> <p>Plan of Correction, dated 6/24/09, stated the facility revised a cleaning list to ensure wheelchairs were being cleaned daily, and had trained the RSC to ensure she was monitoring all individuals' adaptive equipment to ensure cleanliness and good repair.</p> <p>The facility failed to ensure individuals' wheelchairs were kept clean and were maintained in good repair.</p> <p>Repeat Deficiency.</p>	W 436			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13G039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/19/2009</b>
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MM197	16.03.11.075.10(d) Written Plans  Is described in written plans that are kept on file in the facility; and  This Rule is not met as evidenced by: Refer to W312.	MM197	<b>MM197 16.03.11.075.10(d) WRITTEN PLANS</b>  MM197- Refer to W312	
MM213	16.03.11.075.17(b) Training and Habitation  Appropriate training and habilitation programs must be provided to residents with hearing, vision, perceptual, or motor impairments in cooperation with appropriate staff; and This Rule is not met as evidenced by: Refer to W436.	MM213	<b>MM213 16.03.11.075.17(b) TRAINING AND HABILITATION</b>  MM213- Refer to W436	
MM570	16.03.11.210.05(b) Medications and Treatments  A record of all medications and treatments prescribed and administered; and This Rule is not met as evidenced by: Refer to W111.	MM570	<b>MM570 16.03.11.210.05(b) MEDICATIONS AND TREATMENTS</b>  MM570- Refer to W111	

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FACILITY STANDARDS

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

RD2R11

If continuation sheet 1 of 1

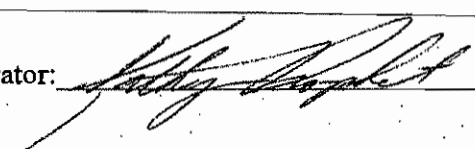
12-2-09  
(X6) DATE

**Plan of Correction Addendum**

Date: 12-09-09

W312- Also to better ensure medications are being used specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed, all clients Person Centered Plans will now be reviewed quarterly by the PCH Behavior Specialist.  
Monitored –monthly by QMRP, Quarterly by Behavior Specialist  
Completion Date- 2-7-09

W436- Monitored – weekly  
Completion Date- 2-7-09

Administrator: 

Date 12-9-09